

Extended Coverage/COBRA Continuation Coverage Election Notice

(Revised 7/10)

Date of Notice (Benefits Administrator/BA should provide information noted in red—instructions to BA are highlighted)

Name and Address: To the former employee and/or other qualified beneficiaries—those covered on the day before the qualifying event who lost coverage due to that event. If there is more than one qualified beneficiary and they all live at the same address, names of all qualified beneficiaries are not required. Instead, you may use their status.

Examples: Just the employee—Mary Smith

Employee and spouse—Mary Smith and spouse

Family coverage—Mary Smith, spouse and dependent children or Mary Smith and dependent children;

Just Mary's daughter—Jane Smith.

Unless you know that all qualified beneficiaries do not live at the same address, one notice, properly addressed, can be mailed to all.

This notice contains important information about your right to continue your health care coverage in the Commonwealth of Virginia Health Benefits Program (the Plan). Please read the information contained in this notice very carefully.

ATTENTION: The following paragraph is directed to individuals receiving this Election Notice due to an involuntary termination of employment that occurred between September 1, 2008 and May 31, 2010, including an involuntary termination during that time that was followed by a severance period.

The American Recovery and Reinvestment Act of 2009 (ARRA), as amended by the Department of Defense Appropriations Act, 2010, the Temporary Extension Act of 2010 (TEA), and the Continuing Extension Act of 2010 (CEA) reduces the COBRA premium in some cases. If the COBRA qualifying event that resulted in your loss of coverage was involuntary termination of employment, and the actual termination occurred during the period that begins with September 1, 2008, and ends with May 31, 2010, you may be eligible for the temporary premium reduction for up to 15 months. This would also include a COBRA qualifying event that was a reduction of hours during the period beginning with September 1, 2008, and ending with May 31, 2010, that was followed by an involuntary termination of employment on or after March 2, 2010, and by May 31, 2010. If you were involuntarily terminated during the period from September 1, 2008, through May 31, 2010, and it was followed by a severance period (e.g., 12-month transition period with continuing health plan coverage) that resulted in a COBRA offer after the defined ARRA eligibility period, you may still be eligible for premium reduction based on the termination date. To help determine whether you can get the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, reference the "Summary of the COBRA Premium Reduction Provisions under ARRA, as Amended" with details regarding eligibility, restrictions, and obligations and the "Application for Treatment as an Assistance Eligible Individual." **If you believe you fulfill the criteria for the premium reduction, complete the *Application for Treatment as an Assistance Eligible Individual* and return it with your completed *Election Form*.**

To elect COBRA continuation coverage, use the instructions on the following pages to complete the enclosed *Election Form* and submit it as indicated.

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on **(enter date that coverage ends due to the qualifying event)** due to: **(check box/es identifying the qualifying event/s)**

- End of employment
 - Involuntary Voluntary (Benefits Administrators--see BA Memo #09-03 for definition)
- Divorce from employee or retiree
- Death of employee or retiree
- Reduction in hours of employment resulting in loss of coverage/loss of employer contribution
- Loss of dependent child status

Each person ("qualified beneficiary") in the category(ies) checked below is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to **(enter 18 or 36 based on the event)** months: **(check appropriate box/es)**

- Employee or former employee
- Spouse or former spouse
- Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
- Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

If elected, COBRA continuation coverage will begin on **(enter first day of COBRA continuation period)** and can last until **(enter last day of the 18th or 36th month)**.

The Commonwealth of Virginia Health Benefits Program allows COBRA qualified beneficiaries to make a plan change (not including a change in claims administrators unless there is a qualifying event that would allow that change) at the start of COBRA coverage; however, if you are an Assistance Eligible Individual, you may not receive premium assistance for a plan that costs more than the plan that you had at the time coverage was lost. A list of plans is provided below.

The cost for COBRA continuation coverage is provided below. (Contact your Benefits Administrator if you need premium rates to continue a Medicare-coordinating plan.) If you qualify as an “Assistance Eligible Individual”, the reduced cost for coverage is also provided below (“Monthly premiums with assistance”), and this premium reduction can last for up to 15 months. You do not have to send any payment with the *Election Form*. Important additional information about payment for COBRA continuation coverage is included in the pages following the *Election Form*.

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact **(enter the name, address and telephone number of the agency Benefits Administrator issuing this notice)**. If you have questions after you elect COBRA continuation coverage, contact the Office of Health Benefits COBRA Administrator (see “For More Information”).

**Commonwealth of Virginia COBRA Premium Rates (18 or 36-month events)
July 1, 2010—June 30, 2011**

Monthly premiums without assistance*

Plan	Single	Two-Person	Family
COVA Care/Connect (CC) Basic	\$510	\$944	\$1,379
CC + Out-of-Network	\$522	\$960	\$1,401
CC + Expanded Dental	\$525	\$974	\$1,424
CC + Vision, Hearing, Expanded Dental	\$537	\$993	\$1,450
CC + Out-of-Network, Expanded Dental	\$538	\$989	\$1,445
CC + Out-of-Network, Vision, Hearing, Expanded Dental	\$548	\$1,009	\$1,471
COVA HDHP	\$409	\$758	\$1,108
Kaiser	\$528	\$974	\$1,421

Monthly premiums with assistance*

Plan	Single	Two-Person	Family
COVA Care/Connect (CC) Basic	\$179	\$330	\$483
CC + Out-of-Network	\$183	\$336	\$490
CC + Expanded Dental	\$184	\$341	\$498
CC + Vision, Hearing, Expanded Dental	\$188	\$348	\$508
CC + Out-of-Network, Expanded Dental	\$188	\$346	\$506
CC + Out-of-Network, Vision, Hearing, Expanded Dental	\$192	\$353	\$515
COVA HDHP	\$143	\$265	\$388
Kaiser	\$185	\$341	\$497

*Premiums will be adjusted to reflect family groups that have both Assistance Eligible and Non-Assistance Eligible Individuals. Retirees enrolled in the State Retiree Health Benefits Program who are also eligible for premium assistance (due to retirement in lieu of involuntary termination) will have the amount of their retiree premium reduced by 65%.

COBRA Continuation Coverage Election Form

Instructions: To elect COBRA continuation coverage, complete this *Election Form* and return it to the address listed below. Under federal law, you have the later of either 60 days after coverage is lost due to the qualifying event or 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed *Election Form* to: **(Name, Address and Telephone Number of The Benefits Administrator issuing this Notice)**

This *Election Form* must be completed, returned by mail, and postmarked no later than **(provide the date at the end of the 60-day election window—no earlier than 60 days after the loss of coverage or 60 days from the date of this notice, whichever is later).**

If you do not submit a completed *Election Form* by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed *Election Form* before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage may begin the first month after you furnish the completed *Election Form*.

Read the important information about your rights included in the pages after this *Election Form*.

I (We) elect COBRA continuation coverage in the Commonwealth of Virginia Health Benefits Program (the Plan) as indicated below. Include names of all qualified beneficiaries who are enrolling.

Name	Date of Birth	Relationship to Employee	Social Sec. No.	*Elect MRA	**Plan Selection	Decline COBRA

*If you wish to continue your existing Medical Reimbursement Account, check here (see following *Important Information* section)

**You may change plans in some cases—see your Election Notice for a summary of plans and premiums.

Signature of Enrollee or Representative _____

Date: _____

Print Name: _____

Relationship to individual(s) listed above: _____

Print Address: _____

Telephone number: _____

If the employee became entitled to Medicare (Part A or B) within the 18 months prior to termination of employment or reduction of hours, please indicate eligibility date here _____.

Important Information About Your COBRA Continuation Coverage Rights

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. Depending on the type of qualifying event, “qualified beneficiaries” can include the employee covered under the group health plan, the covered employee’s/retiree’s spouse, and the dependent children of the covered employee/retiree. Each qualified beneficiary has a separate right to elect continuation coverage. Certain newborns, newly adopted children and children covered through a Qualified Medical Child Support Order (QMCSO) may also be qualified beneficiaries.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment, special enrollment rights, and changes consistent with qualifying mid-year events. Your member handbook contains additional information regarding qualifying mid-year events. Retirement may be a COBRA qualifying event, and retiree coverage may run concurrently with COBRA eligibility.

Medical Reimbursement Accounts

Employees who are enrolled in a Medical Reimbursement Account (MRA) may also choose to extend current participation in that program if, on the event date, the maximum benefit available for the remainder of the plan year is more than the maximum amount that the plan could require as payment for the remainder of the year. If you are eligible to continue your MRA and elect to do so, you will be contacted by Fringe Benefits Management Company.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee’s (or retiree’s) death, divorce, or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee can last until 36 months after the date of Medicare entitlement.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid on time,
- a qualified beneficiary first becomes covered, after electing continuation coverage, under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary,
- a qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

It is the obligation of the qualified beneficiary to notify the Office of Health Benefits COBRA Administrator in writing within 30 days of the start of coverage under another group health plan or Medicare after the election of COBRA/Extended Coverage. Upon report of other group health plan coverage or entitlement to Medicare, COBRA/Extended Coverage will be terminated at the end of the month in which that coverage begins, or if it begins on the first day of the month, the end of the previous month. Failure to report these events within the 30-day time limit will not preclude termination back to the date that coverage would have been terminated had the events been reported on time. Premiums paid during that period will be refunded, and any paid claims will be retracted.

(If the maximum period shown on page one of this notice is less than 36 months, add the following section, "How can you extend the length of COBRA continuation coverage?" If the maximum period on page one is 36 months, leave this section out.)

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage for a maximum period of 18 months, an extension of that period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Office of Health Benefits COBRA Administrator of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

o Disability

An 11-month extension of coverage may be available if any qualified beneficiary is determined under the Social Security Act (SSA) to be disabled. The disability has to have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Notification of the disability determination must be given to the Office of Health Benefits COBRA Administrator within 60 days of either 1.) the date of the disability determination; 2.) the date of the qualifying event; 3.) the date on which coverage would be lost due to the qualifying event; or, 4.) the date on which the qualified beneficiary is informed of the obligation to provide the disability notice (e.g., through this notice or the General Notice), AND within the first 18 months of COBRA/Extended Coverage. Notification must be presented in writing and include the following information:

- The name of the disabled qualified beneficiary (e.g., employee, spouse or dependent child);
- The date of the determination;
- Documentation from the Social Security Administration to support the determination;
- The written signature of the notifying party (qualified beneficiary or representative).

Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one in the family group qualifies. If the qualified beneficiary is determined to no longer be disabled under the SSA, he or she must notify the Plan of that fact within 30 days after that determination by providing documentation from the Social Security Administration. Failure to report the end of the disability status within the 30-day time limit will not preclude termination back to the date that coverage would have been terminated had it been reported on time (the first of the month that is more than 30 days after the determination). Premiums paid during that period will be refunded, and any claims paid will be retracted.

o Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage. Notification should include the following information:

- The type of second qualifying event (e.g., death, divorce, loss of dependent eligibility);
- The name of the affected qualified beneficiary (e.g., spouse and/or dependent child);
- The date of the second qualifying event;
- Documentation to support the occurrence of the second qualifying event (e.g., final divorce decree, dependent child's marriage certificate, proof of child's self-support, death certificate);
- The written signature of the notifying party.

Failure to provide timely and complete notification of the second qualifying event will result in loss of additional COBRA/Extended Coverage eligibility.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the *Election Form* and furnish it to your Benefits Administrator as noted on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage, and electing continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion if you do not elect continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of a qualifying event. You will also have the same special enrollment right at the end of continuation coverage if you maintain continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly-situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is included with this notice.

ATTENTION: The following paragraphs are directed to individuals receiving this Election Notice due to an involuntary termination of employment that occurred between September 1, 2008, and May 31, 2010, including an involuntary termination during that time that was followed by a severance period.

The American Recovery and Reinvestment Act of 2009 (ARRA), as amended by the Department of Defense Appropriations Act, 2010, the Temporary Extension Act of 2010, and the Continuing Extension Act of 2010 reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the eligibility period beginning with September 1, 2008, and ending with May 31, 2010. An involuntary termination of employment that occurs on or after March 2, 2010, but by May 31, 2010, and follows a qualifying event that was a reduction of hours that occurred at any time from September 1, 2008, through May 31, 2010, is also a qualifying event for purposes of ARRA.

This could include employees who retire in lieu of involuntary termination of employment or employees who terminate employment during that period and then exercise their severance benefits before losing coverage and being offered COBRA continuation. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to 15 months. If your COBRA continuation coverage lasts beyond the 15 months, you will have to pay the full amount to continue your COBRA coverage after premium reduction ends. See the attached "Summary of the COBRA Premium Reduction Provisions under ARRA, as Amended" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the *Election Form*. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This period begins upon receipt of your *Election Form*.) If you do not make your first payment for continuation coverage in full by 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the issuer of your bill to confirm the correct amount of your first payment. You may contact the Office of Health Benefits COBRA Administrator if you have questions regarding premium reduction under ARRA (see "For more information").

Claims will not be processed, and covered services will not be paid until you have elected COBRA and made the first payment. Coverage will be available only for months for which the premium has been paid.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage month. Current monthly premium amounts are included with this notice but are subject to change based on annual renewal. You will be notified of any premium change. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of the coverage month. If you make a periodic payment on or before the first day of the coverage month to which it applies,

your coverage under the Plan will continue for that coverage period without any break. The COBRA billing administrator will provide information about how and where to submit your monthly premium payment.

Grace periods for periodic payments

Although periodic payments are due as described above, you will be given a grace period of 30 days after the first day of the coverage month to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. Your continuation coverage will be suspended if your premium is not received by the first of the coverage month, but any claims denied during that period may be resubmitted once premium payment is received before the end of the grace period. Payments are considered made when mailed.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to the address noted on your billing statement.

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. After your initial enrollment, you may obtain additional information about COBRA/Extended Coverage by contacting:

Office of Health Benefits COBRA Administrator
101 N. 14th Street
13th Floor
Richmond, VA 23219

For more information regarding COBRA coverage under the Public Health Service Act for state and local government employees, consult Maximus, a Centers for Medicare and Medicaid Services-sponsored contractor, at www.ContinuationCoverage.net or contact ContinuationCoverage@maximus.com.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the Plan Administrator (Office of Health Benefits COBRA Administrator) informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Attachments: HIPAA Certificate of Creditable Coverage
Summary of COBRA Premium Reduction Provisions under ARRA
Request for Treatment as an Assistance Eligible Individual
Participant Notification



Summary of the COBRA Premium Reduction Provisions under ARRA, as Amended



President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. ARRA has been amended three times: on December 19 2009, by the Department of Defense Appropriations Act, 2010; on March 2, 2010, by the Temporary Extension Act of 2010; and on April 15, 2010, by the Continuing Extension Act of 2010. These laws give “Assistance Eligible Individuals” the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 15 months.

To be considered an “Assistance Eligible Individual” and get reduced premiums you:

- **MUST** have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at any time from September 1, 2008 through May 31, 2010;*
- **MUST** elect the coverage;
- **MUST NOT** be eligible for Medicare; AND
- **MUST NOT** be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse’s employer.¹

*The involuntary termination must occur on or after March 2, 2010, and by May 31, 2010, if it is preceded by a qualifying event that was a reduction of hours occurring at any time from September 1, 2008, through May 31, 2010.

◆ IMPORTANT ◆

- ◇ If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare, you **MUST** notify the plan in writing. If you do not, you may be subject to a tax penalty.
- ◇ Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.
- ◇ The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than \$125,000 (or \$250,000 for married couples filing a joint Federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at www.irs.gov.

For general information regarding your plan’s COBRA coverage you can contact the agency Benefits Administrator who provided this notice (see attached Election Form).

For specific information related to your plan’s administration of the ARRA Premium Reduction or to notify the plan of your ineligibility to continue paying reduced premiums, contact the Office of Health Benefits COBRA Administrator at 101 N. 14th Street, 13th Floor, Richmond, VA 23219.

If you are denied treatment as an “Assistance Eligible Individual” you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction go to: www.ContinuationCoverage.net or contact ContinuationCoverage@maximus.com.

¹ Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

To apply for ARRA Premium Reduction, complete this form and return it along with your COBRA Continuation Coverage Election Form. You may also send this form in separately to: Office of Health Benefits COBRA Administrator, 101 N. 14th Street, 13th Floor, Richmond, VA 23219. You should also read the important information about your rights included in the "Summary of the COBRA Premium Reduction Provisions Under ARRA, as Amended."

Commonwealth of Virginia
Health Benefits Program

**REQUEST FOR TREATMENT AS AN ASSISTANCE
ELIGIBLE INDIVIDUAL**

101 N. 14th Street
13th Floor
Richmond, VA 23219

PERSONAL INFORMATION

0710 Revision

Name and mailing address of employee (list any dependents on the back of this form)	Telephone number (required) or E-Mail address (optional)
	Health plan ID number or Social Security Number

ANSWER THESE QUESTIONS CAREFULLY - To qualify, none of your answers can be "No"*.

1. The loss of employment was involuntary.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The loss of employment occurred at some point on or after September 1, 2008, and on or before May 31, 2010.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. If the loss of employment was preceded by a qualifying event that was a reduction of hours, the reduction of hours took place at some point between September 1, 2008, and May 31, 2010, AND the loss of employment occurred on or after March 2, 2010, but by May 31, 2010 (see Election Notice for more information). If the loss of employment was not preceded by a reduction of hours (e.g., leave of absence), check "N/A".	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
4. I elected (or am electing) COBRA continuation coverage (including retiree coverage elected in place of COBRA coverage).	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming a reduced premium). If you are NOT eligible for other group health plan coverage, check "Yes".*	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium). If you are NOT eligible for Medicare, check "Yes".	<input type="checkbox"/> Yes <input type="checkbox"/> No

*If you checked NO for statement 5 because you are eligible for Commonwealth of Virginia Retiree Health Benefits Program coverage, you may still be eligible for premium assistance. If the only other coverage for which you are eligible is Commonwealth of Virginia Retiree Health Benefits Program coverage (meaning that you are not eligible for any other coverage), please check the following box: Checking this box indicates you are not eligible for any group health plan coverage other than your retiree coverage.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____
Type or print name → _____ Relationship to employee → _____

(Neither Applicant nor Employing Agency should complete this section)
FOR DHRM USE ONLY – DHRM will notify the applicant of approval or denial of premium assistance.
This application is: Approved Denied Approved for some/denied for others (explain in #4 below)
Specify reason below and then return a copy of this form to the applicant.

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

1. Loss of employment was voluntary.	<input type="checkbox"/>
2. The involuntary loss did not occur between September 1, 2008 and May 31, 2010.	<input type="checkbox"/>
3. The qualifying event was a reduction of hours and was not followed by a termination of employment (or the termination occurred prior to March 2, 2010, or after May 31, 2010).	<input type="checkbox"/>
4. Individual did not elect COBRA coverage.	<input type="checkbox"/>
5. Other (please explain)	<input type="checkbox"/>

Signature of Office of Health Benefits COBRA Administrator.
→ _____ Date → _____
Type or print name → _____
Telephone number → _____ E-mail address → _____

DEPENDENT INFORMATION (Parent or guardian should sign for minor children.)

Name Date of Birth Relationship to Employee SSN (or other identifier)

a. _____

1. I elected (or am electing) COBRA continuation coverage (including retiree coverage elected in place of COBRA coverage).	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage (other coverage does not include state program retiree coverage).	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

Name Date of Birth Relationship to Employee SSN (or other identifier)

b. _____

1. I elected (or am electing) COBRA continuation coverage (including retiree coverage elected in place of COBRA coverage).	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage (other coverage does not include state program retiree coverage).	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

Name Date of Birth Relationship to Employee SSN (or other identifier)

c. _____

1. I elected (or am electing) COBRA continuation coverage (including retiree coverage elected in place of COBRA coverage).	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage (other coverage does not include state program retiree coverage).	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature → _____ Date → _____

Type or print name → _____ Relationship to employee → _____

Use this form to notify your plan that you have become eligible for other group health plan coverage or Medicare AFTER you begin receiving premium assistance and are, therefore, no longer eligible for reduced premiums under ARRA.

Commonwealth of Virginia
Health Benefits Program
Office of Health Benefits
COBRA Administrator

Participant Notification

101 N. 14th Street
13th floor
Richmond, VA 23219

PERSONAL INFORMATION

Name and mailing address

Telephone number (required) or e-mail address (optional)

Health plan ID number or Social Security Number

PREMIUM REDUCTION INELIGIBILITY INFORMATION – Check one

I am eligible for coverage under another group health plan.
If any dependents are also eligible, include their names below.

Insert date you became eligible _____

I am eligible for Medicare.

Insert date you became eligible _____

IMPORTANT

If you fail to notify your plan of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced COBRA premiums you could be subject to a fine of 110% of the amount of the premium reduction.

Eligibility is determined regardless of whether you take or decline the other coverage.

However, eligibility for coverage does not include any time spent in a waiting period.

To the best of my knowledge and belief all of the answers I have provided on this Form are true and correct.

Signature → _____ Date → _____

Type or print name → _____

If you are eligible for coverage under another group health plan, and that plan covers dependents, you must also list their names here:

